EXHIBIT A

From: Brian Neville
To: Matthias, Michael; Barry Lax; Robert Miller
Cc: Lovullo, Lisa
Subject: RE: 10-05169 Fairfield Pagma Associates, LP
Date: Wednesday, January 27, 2016 11:44:00 AM
Attachments: death certificate.pdf

Michael,

We received the death certificate for Seymour Kleinman. We still wish to withdraw as counsel and will reach out to you shortly regarding doing so but wanted to get this to you as we have both been waiting for it for so long.

Brian J. Neville
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I hereby certify that the foregoing is a true and correct copy of the death record on file with the Office of the City Clerk. 255 Main Street, White Plains, NY
IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Corporate Seal of The City of White Plains, NY

Registrar of Vital Statistics of The City of White Plains, NY

RECORD NUMBER: 3902
REGISTER NUMBER: 469

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE

MCHS

4C

4G

DECEDENT

7A

7B

S1

25

30

31

31B

OR

OS

0C0D

CANCER

DISPOSITION

CERTIFIER

CAUSE OF DEATH

1. NAME: FIRST: Seymour | MIDDLE: | LAST: Kleinman
2. SEX: MALE ☒ 1 | FEMALE ☐ 2
3A. DATE OF DEATH: MONTH 09 | DAY 08 | YEAR 2015
3B. HOUR: 5:33 p.m.
4A. PLACE OF DEATH (Check one): HOSPITAL DOA ☐ ER ☐ | HOSPITAL OUTPATIENT ☐ | HOSPITAL INPATIENT ☐ | NURSING HOME ☐ | PRIVATE RESIDENCE ☒ | HOSPICE FACILITY ☐ | OTHER (Specify) ☐
4B. IF FACILITY, DATE ADMITTED: MONTH | DAY | YEAR
4C. NAME OF FACILITY: (If not facility, give address) 11 Brook Hills Circle
4D. LOCALITY: (Check one and specify) CITY ☒ | VILLAGE ☐ | TOWN ☐ White Plains
4E. COUNTY OF DEATH: Westchester
4F. MEDICAL RECORD NO.:
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ | YES ☐
5. DATE OF BIRTH: MONTH 06 | DAY 28 | YEAR 1924
6A. AGE IN YEARS: 91 yrs.
6B. IF UNDER 1 YEAR ENTER: months | days
6C. IF UNDER 1 DAY ENTER: hours | minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Bronx, New York
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐ 0 | YES ☒ 1
1943-1946
9. DECEDENT OF HISPANIC ORIGIN? (Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.)
A ☒ No, not Spanish/Hispanic/Latino | B ☐ Yes, Mexican, Mexican American, Chicano | C ☐ Yes, Puerto Rican | D ☐ Yes, Cuban | E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: (Check one or more races to indicate what the decedent considered himself or herself to be:)
A ☒ White/Caucasian | B ☐ Black or African American | C ☐ Asian Indian | D ☐ Chinese | E ☐ Filipino | F ☐ Japanese | G ☐ Korean | H ☐ Vietnamese | J ☐ Native Hawaiian | K ☐ Guamanian or Chamorro | M ☐ Samoan | N ☐ American Indian or Alaska Native (Specify) | P ☐ Other Asian (Specify) | R ☐ Other Pacific Islander (Specify) | S ☐ Other (Specify)
11. DECEDENT'S EDUCATION: (Check the box that best describes the highest degree or level of school completed at the time of death.)
1 ☐ ≤ 8th grade | 2 ☐ 9th-12th grade; no diploma | 3 ☐ High school graduate or GED | 4 ☐ Some college credit, but no degree | 5 ☐ Associate's degree | 6 ☒ Bachelor's degree | 7 ☐ Master's degree | 8 ☐ Doctorate/Professional degree
12. SOCIAL SECURITY NUMBER: [redacted]
13. MARITAL STATUS: NEVER MARRIED ☐ 1 | MARRIED ☒ 2 | WIDOWED ☐ 3 | DIVORCED ☐ 4 | SEPARATED ☐ 5
14. SURVIVING SPOUSE: (Enter birth name of spouse if married or separated.) Judith V. Shapiro
15A. USUAL OCCUPATION: (Do not enter retired) Accountant
15B. KIND OF BUSINESS OR INDUSTRY: Accounting
15C. NAME AND LOCALITY OF COMPANY OR FIRM: N/A
16A. RESIDENCE: (State or Country if not USA) New York
16B. County or Region/Province if not USA: Westchester
16C. LOCALITY: (Check one and specify) CITY ☒ | VILLAGE ☐ | TOWN ☐ White Plains
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☒ YES ☐ NO (IF NO, SPECIFY TOWN:
16D. STREET AND NUMBER OF RESIDENCE: 11 Brook Hills Circle
16E. ZIP CODE: 10605
17. BIRTH NAME OF FATHER / PARENT: FIRST Joseph | MI | LAST Kleinman
18. BIRTH NAME OF MOTHER / PARENT: FIRST Ida | MI | LAST Schneider
19A. NAME OF INFORMANT: Judith V. Kleinman
19B. MAILING ADDRESS: (Include zip code) 11 Brook Hills Circle - White Plains, New York 10605
20A. 1 ☒ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT | MONTH 09 | DAY 10 | YEAR 2015
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Wellwood Cemetery
20C. LOCATION: (City or town and state) Farmingdale, New York
21A. NAME AND ADDRESS OF FUNERAL HOME: Riverside Memorial Chapel | 21 West Broad Street, Mount Vernon, New York 10552
21B. REGISTRATION NUMBER: 01479
22A. NAME OF FUNERAL DIRECTOR: Angelo Ambrosino
22B. SIGNATURE OF FUNERAL DIRECTOR:
22C. REGISTRATION NUMBER: 10061
23A. SIGNATURE OF REGISTRAR:
23B. DATE FILED: MONTH 9 | DAY 9 | YEAR 2015
24A. BURIAL OR REMOVAL PERMIT ISSUED BY:
24B. DATE ISSUED: MONTH 9 | DAY 9 | YEAR 2015

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN - OR - CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: Maxwell Christ MD | License No.: 116529 | Signature: | Month 9 | Day 9 | Year 15
Certifier's Title: 0 ☒ Attending Physician | 0 ☐ Physician acting on behalf of Attending Physician | 1 ☐ Coroner | 2 ☐ Medical Examiner / Deputy Medical Examiner | Address:
25B. If coroner is not a physician, enter Coroner's Physician's name & title: | License No.: | Signature: | Month | Day | Year
25C. If certifier is not attending physician, enter Attending Physician's name & title: | License No.: | Address:
26A. Attending physician attended deceased: FROM | TO 9 8 15
26B. Deceased last seen alive by attending physician: 8 27 15
26C. Pronounced Dead ON: 9 8 15 AT 5:33 PM
27. MANNER OF DEATH: NATURAL CAUSE ☒ 1 | ACCIDENT ☐ 2 | HOMICIDE ☐ 3 | SUICIDE ☐ 4 | UNDETERMINED CIRCUMSTANCES ☐ 5 | PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO | 1 ☒ YES
29A. AUTOPSY? NO ☒ 0 | YES ☐ 1 | REFUSED ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO | 1 ☐ YES

CONFIDENTIAL | SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH | CONFIDENTIAL

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)
PART I. IMMEDIATE CAUSE: (A) Congestive Heart Failure
DUE TO OR AS A CONSEQUENCE OF: (B) AS HD
DUE TO OR AS A CONSEQUENCE OF: (C)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): DM, HBP, Alzheimer's Disease
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO | 1 ☐ YES | 2 ☐ PROBABLY | 3 ☐ UNKNOWN
31A. IF INJURY, DATE: MONTH | DAY | YEAR | HOUR:
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☐ 0 | YES ☐ 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator | 2 ☐ Passenger | 3 ☐ Pedestrian | 4 ☐ OTHER (Specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐ 0 | YES ☐ 1
33A. IF FEMALE: 0 ☐ Not pregnant within last year | 1 ☐ Pregnant at time of death | 2 ☐ Not pregnant, but pregnant within 42 days of death | 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death | 4 ☐ Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH | DAY | YEAR

For use by physician or Institution:
NAME OF DECEDENT:
TIME OF DEATH: AM PM
DATE OF DEATH: